

William R. Work, M.D.  
Ultimate Living Medical Clinic

Today's Date: \_\_\_\_\_



UltimateLiving  
MEDICAL CLINIC

Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Separated \_\_\_\_

Social Security # \_\_\_\_\_ Occupation \_\_\_\_\_

Email address: \_\_\_\_\_ Cell#: \_\_\_\_\_

Employed by \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Ext \_\_\_\_\_ Calls Allowed?  Yes  No

Spouse or Parent \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Employed by \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Responsible Party \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Name of person carrying insurance \_\_\_\_\_ Relationship to pt \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

**Appointments:** Appointment times are valuable to yourself as well as other patients. Please be courteous and give us at least 24 hours before canceling. **If you fail to do so, there will be a charge of \$25.00 billed to your account.**

**Financial Policy:** As a courtesy, we will submit today's charges to your insurance carrier. Your payment/co-payment is expected at each visit. We have MasterCard and VISA services available for your convenience. After acknowledgement is received from your insurance company, we will bill you for any outstanding balance. We encourage our patients to remit any account balance, in full, upon receipt of the first statement. This will reduce the chances of an administrative fee for statement rebilling.

**Assignment of benefits:** I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled to: William R. Work, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I authorize Dr. William R. Work to provide me reasonable and proper medical care by today's standards.

Further, I understand that I am entering into a contractual relationship with Ultimate Living Medical Clinic and/or Dr. Work for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Ultimate Living Medical Clinic and/or Dr. Work, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Ultimate Living Medical Clinic and/or Dr. William R. Work.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use AMBS board-certified expert medical witness(es) in the same or similar specialty as Dr. Work. Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, I, William R. Work, M.D., agree to the same stipulations.

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Patient

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Date